Notification: Effective 08/13/2022 Cigna will require the submission of documentation to support the use of modifier 25 when billed with E/M CPT codes 99212 – 99215 and a minor procedure

Reimbursement Policy

Effective Date.....04/13/2015
Reimbursement Policy Number M25

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

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Related Policies

Modifier 59 - Distinct Procedural Service
R02 - Preventive Medicine Evaluation and Management Service and Problem Based Evaluation and Management Service on the Same Day
R23 - Global Surgical Package and Related Modifiers Policy
R30 – Evaluation and Management Services
R36 – Emergency Room Services
R37 – Advanced Practice Healthcare Providers

INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy Proprietary information of Cigna. Copyright ©2022 Cigna*

Overview

In general, reimbursement for evaluation and management services on the same day a procedure is also performed by the same physician is included in the payment for the procedure. The E/M service code should not be separately reported.

In some circumstances, a significant E/M service is rendered that is separately identifiable from the procedure performed in the same session. The separate E/M service must be significant enough to require a separate service, i.e., address a new or distinct problem.

Modifier 25 was created to identify this situation and to indicate that it is appropriate to separately report the E/M service in addition to the procedure. Modifier 25 is used to indicate that on the day a procedure was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided.

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Cigna allows separate reimbursement for an Evaluation and Management (E/M) service or office visit when reported in addition to a procedure on the same date of service if:

- **the Current Procedural Terminology (CPT®) or Health Care Procedure Coding System (HCPCS) E/M service code (e.g., CPT 99202-99499) and a procedure performed at the same patient encounter are individually and separately identifiable, and**
- **modifier 25 is appended to the disallowed E/M service code, and**
- **the Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI), or Cigna defined edit allows a modifier override, and**
- **the supporting documentation satisfies the key component criteria for the level of the Evaluation and Management service as defined by CMS in the 1997 Documentation Guidelines for Evaluation and Management Services**
- **Cigna requires the submission of office notes with claims submitted with E/M CPT® codes 99212, 99213, 99214 and 99215, and modifier 25 when billed with a minor procedure. The E/M line will be denied if Cigna does not receive adequate documentation to support that a significant and separately identifiable service was performed. The documentation should be submitted with a cover sheet indicating the office notes supports the use of modifier 25 appended to the E/M code.**

Note: Only specific NCCI edits require supporting documentation to be submitted with the initial claim (see below).

General Background

In general, reimbursement for evaluation and management services on the same day a procedure is also performed by the same physician is included in the payment for the procedure. The E/M service code should not be separately reported.

In some circumstances, a significant E/M service is rendered that is separately identifiable from the procedure performed in the same session. The separate E/M service must be significant enough to require a separate service, i.e., address a new or distinct problem.

Modifier 25 usage

Modifier 25 was created to identify this situation and to indicate that it is appropriate to separately report the E/M service in addition to the procedure. Modifier 25 is used to indicate that on the day a procedure was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided.

The necessity for an independent E/M service may be prompted by a complaint, symptom, condition, problem, or circumstance that may or may not be related to the procedure performed by the same provider on the same date of service. As such, it is not necessary to present diagnoses different from those related to the procedure to report a significant, separately identifiable E/M service.

When a procedure is performed as a follow-up service or is scheduled as the primary reason for a patient encounter, reporting an E/M service is only warranted if a significant, separately identifiable condition arises or a new problem is identified.

When the disallowed code is an E/M CPT® code, with modifier 25, and a minor procedure the documentation should demonstrate the E/M is significant and separately identifiable. CMS defines a minor procedure with a global days of 000 to 10. "In general, E&M services on the same date of service as the minor surgical procedure

are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses."

Cigna requires the submission of office notes with claims submitted with E/M CPT® codes 99212, 99213, 99214 and 99215, and modifier 25 when billed with a minor procedure. The E/M line will be denied if Cigna does not receive adequate documentation to support that a significant and separately identifiable service was performed. The documentation should be submitted with a cover sheet indicating the office notes supports the use of modifier 25 appended to the E/M code.

Examples of Incorrect Use of Modifier 25

- Appending modifier 25 to a CPT or HCPCS service code that is not an Evaluation and Management (E/M) code.
- Appending modifier 25 to a CPT or HCPCS service code when the patient's condition does not warrant an E/M service in addition to the procedure performed on that date.
- Using modifier 25 to indicate the need for a major surgery the day of or day after the E/M visit. (Modifier 57 should be used.).

Multiple Patient Encounters on the Same Day

Evaluation and management service codes should be selected based on their key components and contributory factors. Generally, only one E/M service code is appropriately reported per day. Because the E/M services are based on levels of complexity and components defining the services included, there is a broad range of codes from which to select the most appropriate E/M code. Only the code that most specifically represents the services provided in a particular patient encounter should be chosen to report those services.

For this reason, Cigna does not reimburse two E/M service codes submitted for the same date of service unless the presenting situation is one of the exception scenarios noted below. Generally, the service code with the higher Relative Value Unit (RVU) will be considered for reimbursement.* The CMS Medically Unlikely Edit (MUE) of 2 for codes 99212, 99213 and 99214 is excluded from editing as it conflicts with this reimbursement policy indicating that we only pay 1 E/M service per health care professional per single date of service.

One exception to reporting multiple patient encounters in one day is that of prolonged services with direct face-to-face patient contact (CPT 99354, 99355). When appropriate, these codes may be used in conjunction with another E/M code for the same date of service.

Another exception to multiple patient encounter reporting is submitting a preventive medicine office visit (CPT 99381-99397) with a problem-based office visit (CPT 99202-99215). In some cases reporting both office visits may be appropriate. In these situations append modifier 25 to the E/M code that would otherwise be disallowed* to indicate a significant, separately identifiable E/M service was provided. See the *Preventive Medicine Evaluation and Management Service and Problem Based Evaluation and Management Service on the Same Day* Reimbursement Policy under the related links section at the top of this policy for more information.

Prior to February 17, 2014, we used ClaimCheck™ as our code auditing disclosure tool. Effective February 17, 2014, we began using ClaimsXten™, a clinical code editing software developed by Change Healthcare, for medical and behavioral products.

ClaimsXten helps to facilitate accurate claim processing for medical and behavioral claims submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 claim form. ClaimsXten code auditing is based on assumptions regarding the most common clinical scenarios for services performed by a health care professional for the same patient.

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ClaimsXten logic is based upon a thorough review by physicians of current clinical practices, specialty society guidance, and industry standard coding. Viewing claim code edits can be made easier with Clear Claim Connection™. This disclosure tool, also powered by Change Healthcare, allows you to enter Current Procedural Terminology (CPT®) and Health Care Procedure Coding System (HCPCS) codes and immediately view their audit results. Clinical Edit Clarifications offer the rationale behind an edit.

You can access Clear Claim Connection by logging into CignaforHCP.com and clicking on "Claim Coding Edits" at the top of the screen.

Incidental Edits

The Incidental edit identifies a procedure(s) that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI or) to "promote national correct coding methodologies and to eliminate improper coding leading to inappropriate reimbursement".

"The NCCI edits reference pairs of Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System© (HCPCS) Level II codes which are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same patient on the same date of service."

The column 1/column 2 correct coding edit table contains two types of code pair edits. One type contains a column 2 (component) code which is an integral part of the column 1 (comprehensive) code. The other type contains code pairs that should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If two codes of a code pair edit are billed by the same provider for the same beneficiary for the same date of service without an appropriate modifier, only the column 1 code is paid. If clinical circumstances justify appending a CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed.

CMS determines if appending a modifier to the disallowed service code in an NCCI Column1/Column 2 edit is appropriate. The table below lists the CMS designations for modifier use with NCCI Column 1/Column 2 edits.

	CMS National Correct Coding Initiative (NCCI) Incidental (Column 1 / Column 2) Code Edits Assigned numbers identify if a modifier may override an NCCI Incidental edit.
0	**Modifier is not allowed to override the edit.**
1	**Modifier is allowed to override the edit.**
9	**Modifier is not applicable to override the edit.**

The modifier designations (0, 1, and 9) are posted for each edit. Only National Correct Coding Initiatives Column 1/Column 2 edits to which CMS assigns a modifier '1' designation will be considered for separate reimbursement when modifier 25 is appended to the disallowed service code.

To view the complete list of NCCI Column 1/Column 2 edits connect to the CMS website at this address:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp

For certain specific NCCI Column 1/Column 2 edits associated with modifier 25, Cigna requires supporting documentation to be submitted with the initial claim submission for proper consideration of separate reimbursement for the disallowed code. The documentation must satisfy the key component criteria for the level of the E/M service as defined by the CMS 1997 Documentation Guidelines for Evaluation and Management Services. The documentation must also demonstrate the patient's condition was significant enough to:

- warrant a separately identifiable E/M service on the same day as the a reported procedure, or
- exceed the usual pre-operative and post-operative care included in the procedure reported on that date ("global period").

Modifier 57 and Modifier 59

Modifier 57 (Decision for surgery) should be appended to the E/M code to indicate that the E/M service resulted in the initial decision to perform major surgery either that day or the next. Surgeries to which CMS assigns a 90-day follow-up period are considered major surgeries. Refer to the *Global Surgical Package and Related Modifier Reimbursement Policy* (R23) for additional information.

Modifier 59 (Distinct Procedural Service) is appropriate to identify a separate / distinct non-E/M service. See the *Modifier 59 Policy (M59)* for details.

References

1. American Medical Association. Current Procedural Terminology (CPT®) ©2022 Professional Edition.
2. CMS 1997 Documentation Guidelines for Evaluation and Management Services©.
3. Deborah J. Grider, Coding with Modifiers 5th edition (Chicago, IL: American Medical Association, ©2014), 50-70.
4. Optum360, Understanding Modifiers 2022 (USA: Optum360, ©2021), 13-26.
5. CMS, NCCI Manual, Chapter 11 Medicine Evaluation and Management CPT Codes 90000 – 00000 Section U number 6. Accessed 05/06/2022 https://www.cms.gov/files/document/chapter11cptcodes90000-99999final11.pdf

Policy History/Update

Date	Change/Update
05/13/2022	Notification: Effective 08/13/2022 Cigna will require the submission of documentation to support the use of modifier 25 when billed with E/M CPT codes 99212 – 99215 and a minor procedure. Added policy language, updated template update and reference section.
01/07/2021	Code 99201 is being deleted effective 12/31/2020. Changed the code ranges to begin with 99202.Updated the reference section and the policy reference section with the R30.
01/31/2019	Removed the coding Billing Information section as policy does not require specific section. Updated 2019 date in legal statement at the top and updated legal statement at bottom. Updated CPT reference date.
11/06/2018	Updated template, and reference section. Added the overview section
09/28/2017	Changed the name McKesson to Change Healthcare
11/01/2016	Policy template updated.
07/13/2015	Effective Date 07/13/2015 for 99212-99214 exclusion from code editing.
04/14/2015	Notification of identification that the CMS MUE edit of 2 on 99212 – 99214 is excluded from code editing due to policy conflict. Revised reference of the Modifier 57 Policy to Global Surgical Package and Related Modifier Reimbursement Policy (R23).
05/27/2014	Template update, Added ClaimsXten information, updated links, updated references
05/23/2011	Policy template updated, documented change from Claim Check to ClaimsXten, updated link to ClaimsXten

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Date	Change/Update
01/21/2010	Updated language in the Reimbursement section for the documentation required and included CMS 1997 Documentation Guidelines for Evaluation and Management Services
08/06/2009	Policy effective for former Great-West Healthcare.
05/06/2009	Policy notification for former Great-West Healthcare.
04/20/2009	Effective date of CIGNA HealthCare policy update with National Correct Coding Initiative (NCCI) Incidental edits requiring supporting documentation.